1.0 Description of the Procedure

Noninvasive pulse oximetry measures oxygen saturation using a probe. Oxygen saturation is determined by measuring the light absorption of oxygenated hemoglobin and total hemoglobin in arterial blood.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Procedure is Covered

1. Noninvasive pulse oximetry is covered when it is medically necessary to evaluate conditions commonly associated with oxygen desaturation.
2. Continuous overnight pulse oximetry is covered when a recipient would otherwise require hospitalization solely for continuous overnight monitoring. The oximeter must be preset, self sealed and not adjustable by the recipient or anyone in the home.
   - The device must provide a printout that documents an adequate number of sampling hours, percent of oxygen saturation and an aggregate of the results.
   - The results of the test must be reliable and maintained in the medical record.

4.0 When the Procedure is Not Covered

Noninvasive pulse oximetry is not covered when the medical criteria listed in **Section 3.0** are not met. Noninvasive pulse oximetry is not covered when it is not medically necessary to evaluate oxygen desaturation or when the policy guidelines are not followed.

5.0 Requirements for and Limitations on Coverage

Routine testing (in the absence of signs or symptoms suggestive of desaturation) is not covered by the Medicaid program.

6.0 Providers Eligible to Bill for the Procedure

Physicians, non-physician practitioners and health departments, enrolled as Medicaid providers who perform this service, may bill Medicaid.

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in the Medicaid Managed Care programs.

7.0 Additional Requirements

There are no additional requirements.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

8.1 Claim Type

Providers bill professional services on the CMS-1500 (HCFA-1500) claim form.

8.2 Diagnosis Codes the Support Medical Necessity

Providers must bill the ICD-9-CM diagnose codes to the highest level of specificity that supports medical necessity.

8.3 Procedure Codes

CPT codes that are covered by the Medicaid program include:

- 94760
- 94761
- 94762

Noninvasive pulse oximetry CPT codes 94760 and 94761 must not be billed when another covered Medicaid service is billed by the same provider on the same date of service.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1989

Revision Information:

Date	Section Updated	Change
12/01/01	Section 8.0	Method of Reimbursement
12/01/03	Section 3.0	Items 2 and 3 were combined to clarify that the requirements for continuous overnight pulse oximetry.
12/01/03	Section 4.0	The sentence "Noninvasive pulse oximetry is not covered when the medical criteria listed in Section 3.0 are not met." was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.0	This section was reformatted into four subsections.
12/01/03	Section 8.3	Text was added to clarify that CPT codes 94760 and 94761 must not be billed when another covered Medicaid service is billed by the same provider on the same date of service.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.